BILL LOCKYER, Attorney General
of the State of California
JOHN E. DeCURE, State Bar No. 150700
Deputy Attorney General
California Department of Justice
300 So. Spring Street, Suite 1702
Los Angeles, CA 90013
Telephone: (213) 897-8854
Facsimile: (213) 897-9395

Attorneys for Complainant

BEFORE THE
BOARD OF PSYCHOLOGY
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	Case No. W230
JOEL L. SIEGEL, PH.D.	OAH No. L2002050464
Psychologist's License No. PSY 7904,	**STAY OF EXECUTION OF DECISION AND ORDER**
Respondent.	[Gov. Code, §11519(b)]

Pursuant to its authority under Government Code section 11519, subsection (b), the Board of Psychology hereby stays the effective date of its Decision and Order in the above-entitled matter as follows: The previously-ordered effective date of January 12, 2005, is extended seven (7) days. The new effective date is January 19, 2005.

IT IS SO ORDERED January 11, 2005.

BOARD OF PSYCHOLOGY
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

By Jacqueline Horn, Ph.D.

JACQUELINE HORN, PRESIDENT

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BEFORE THE
BOARD OF PSYCHOLOGY
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	Case No.: W230
JOEL L. SIEGEL, Ph.D.	OAH No.: L2002050464
Psychologist's License No. PSY 7904,	
Respondent.	

DECISION

The attached Proposed Decision of the Administrative Law Judge is hereby adopted by the Board of Psychology as its Decision in the above-entitled matter.

This Decision shall become effective January 12, 2005.

IT IS SO ORDERED December 13, 2004.

BOARD OF PSYCHOLOGY
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

By Jacqueline Horn, Ph.D.
JACQUELINE HORN, Ph.D., President

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BEFORE THE
BOARD OF PSYCHOLOGY
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **JOEL L. SIEGEL, Ph.D.** **Psychologist's License No. PSY 7904** **Respondent.**	**Case No. W230** **OAH No. L2002050464**

PROPOSED DECISION

This matter came on regularly for hearing on November 17 and 18, 2003, June 6, July 19, 20, 21, 22, 23, 26, 27, 28, 29, 30, August 5, and September 30, 2004, in Los Angeles, California, before H. Stuart Waxman, Administrative Law Judge, Office of Administrative Hearings, State of California.

On November 17 and 18, 2003, Thomas S. O'Connor (Complainant), was represented by Taylor Schneider, Deputy Attorney General. Complainant was represented by John DeCure, Deputy Attorney General, on all other dates.

Joel L. Siegel, Ph.D. (Respondent), was represented by Daniel Koller, M. Gayle Askren and M. David Meagher, Attorneys at Law.[1]

On August 5, 2004, Complainant amended the First Amended Accusation by striking Paragraph 12(C) and by striking the Sixth Cause for Discipline.

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[1] Not all of Respondent's attorneys appeared on each day of the trial.

On September 30, 2004, Complainant amended the First Amended Accusation as follows:

a. At page 3, line 21, "728" was changed to "729."[2]

b. At page 3, lines 21 and 22, the words, "within two years following termination of therapy" were deleted and replaced with "when the relationship was terminated primarily for the purpose of engaging in that act."

Oral and documentary evidence was received. The record was closed on October 15, 2004, and the matter was submitted for decision.

FACTUAL FINDINGS

The Administrative Law Judge makes the following Factual Findings:

1. Thomas O'Connor made the Accusation and First Amended Accusation in his official capacity as Executive Officer of the Board of Psychology of the State of California (the Board).

2. On January 31, 1983,[3] the Board issued Psychologist's License No. PSY 7904 to Respondent. The license was scheduled to expire on April 30, 2004 unless renewed. The Board maintains jurisdiction over this matter pursuant to Business and Professions Code section 118, subdivision (b).[4]

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[2] The reference to "729" is part of a quote of Business and Professions Code section 2960.1. The statute actually reads "728."

[3] According to the First Amended Accusation and Respondent's testimony, Respondent has been licensed as a psychologist in California since 1983. However, according to the license certification (Complainant's Exhibit 5), the license was issue on January 31, 1993. Based on Respondent's work history, the 1993 date on the license certification is deemed a typographical error.

[4] All statutory references are to the Business and Professions Code unless otherwise indicated.

3. The events referenced herein occurred during the inclusive years 1993 through 1998. During those inclusive years, section 2960 provided in relevant part:

> The board may refuse to issue any registration or license, or may issue a registration or license with terms and conditions, or may suspend or revoke the registration or license of any registrant or licensee if the applicant, registrant, or licensee has been guilty of unprofessional conduct. Unprofessional conduct shall include, but not be limited to:
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> ¶ . . . ¶
>
> (o) Any act of sexual abuse, or sexual relations with a patient, or sexual misconduct that is substantially related to the qualifications, functions or duties of a psychologist or psychological assistant.

In January 1999, the statute was amended to read in relevant part:

> (o) On and after January 1, 2001, any act of sexual abuse, or sexual relations with a patient, or sexual misconduct that is substantially related to the qualifications, functions or duties of a psychologist or psychological assistant.
>
> (p) Commencing January 1, 1999, until January 1, 2001, any act of sexual abuse, or sexual relations with a patient or former patient within two years following termination of therapy, or sexual misconduct which is substantially related to the qualifications, functions or duties of a psychologist or psychological assistant or registered psychologist.

The same portion of section 2960 currently states:

> (o) Any act of sexual abuse, or sexual relations with a patient or former patient within two years following termination of therapy, or sexual misconduct that is substantially related to the qualifications, functions or duties of a psychologist or psychological assistant or registered psychologist.

The version of section 2960 applicable to this case is the version in effect during the inclusive years 1993 through 1998, prior to the 1999 amendment.

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4. This case involves Respondent's treatment of a family, consisting of a husband/father (L.O.), wife/mother (J.O.), daughter (M.O.) and son (E.O.),[5] in conjoint and/or individual psychotherapy at various times during 1993 through 1998,[6] and Respondent's sexual relationship with J.O. commencing in 1998. For the reasons set forth below, J.O. is deemed to have been a former patient at the time the sexual relationship commenced.

5. Respondent is a clinical psychologist who, at all relevant times, maintained a private practice in La Mesa, California. He is a former Director of Psychology at Rancho Park Hospital, former Director of Adolescent Programs at Charter Hospital, and former Director of Community Health Care Alternatives, a facility for inpatients with substance abuse and psychiatric disorders. Respondent is presently the Clinical Director of the Post Adolescent Recovery Center (PARC) in Escondido, where he treats adults with substance abuse problems and concurrent psychiatric disorders.

The Therapy and the Affair

6. In November 1993, M.O., then an adolescent, began individual psychotherapy with Respondent following a referral by her school. M.O. was brought to the initial visit with Respondent by L.O., her father. Thereafter, her mother, J.O., brought her to all therapy sessions. J.O. remained in the waiting room during the early sessions which occurred approximately once each week. After several sessions, the process changed such that M.O. saw Respondent for approximately 30 minutes, J.O. would then speak with Respondent alone for a few minutes, and then Respondent would meet with both M.O. and J.O. for the remainder of the session.

7. Respondent subsequently began discussing with J.O. her own issues, commenting several times on J.O.'s severe depression, detachment from her family and lack of self-esteem. Respondent eventually suggested that J.O. enter into individual psychotherapy with him. J.O. was reluctant to do so, but did become Respondent's patient approximately six months after M.O. began her psychotherapy with him.

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[5] The family members'/patients' initials are used in lieu of their names in order to protect their privacy.

[6] Another son, T.O., is also referenced herein, but was not Respondent's patient.

8. J.O. had been raised by a verbally abusive father whom she described as "a tyrant." She was a former victim of multiple sexual abuses by a priest, and had numerous symptoms consistent with borderline personality disorder. It was difficult for J.O. to discuss her sexual abuse with Respondent and, when they began discussing sexual details, she informed him that she did not believe she could discuss them with a male therapist. Respondent told her he believed it was important for her to discuss them with a male therapist and that he would check with an expert in clergy abuse. He later told her that he had checked and confirmed his belief that she should remain with a male therapist.

9. J.O. was unable to trust Respondent immediately. However, she gained that trust after several sessions and thereafter did not question anything he did. She felt a sense of helplessness in therapy with Respondent. During her therapeutic sessions, Respondent asked J.O. numerous questions about J.O.'s sexual relationship with her husband, including details about her sexual preferences. J.O. found it difficult to discuss those issues. During the sessions, Respondent attempted to console J.O. by sitting next to her on the couch, putting his arm around her, and touching her hand and knees. He also paid her several compliments, most of which related to her attractiveness and his finding her attractive, and he made numerous other comments J.O. considered to be sexual in nature. On one occasion, when J.O. returned from her grandfather's funeral, Respondent kissed her on the forehead. Although J.O. interpreted the kiss as a sign of excitement after not seeing her for a few weeks, she did not view it as a sexual act. It nonetheless made her feel uncomfortable.

10. Respondent repeatedly reassured J.O. that he would not hurt her and that all of his advice would be "sage" (J.O.'s term). Although she was uncomfortable with Respondent's questions and comments relating to her sex life and her attractiveness, J.O. believed she was misunderstanding them.

11. During the course of her therapy sessions, J.O. became aware of an organization for the victims of clergy abuse known by the acronym S.N.A.P. Respondent suggested she look into it. Respondent also suggested that J.O. see a friend of his who could prescribe sleep medication for her.

12. In August of 1996, M.O. ran away from home. J.O. used that event as a reason to terminate her therapy with Respondent. She felt more confused than enlightened by the therapy, and she believed Respondent was not helping her. In a progress note for J.O. dated August 19, 1996, Respondent wrote "Pt [patient] d/c [discontinued] or as needed." During that session, Respondent recommended that J.O. treat with another psychotherapist with whom L.O. was already familiar.

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13. Between 1993 and 1996, Respondent also engaged in conjoint therapy between various members of the family. For example, in addition to seeing M.O. in individual therapy, Respondent saw M.O., J.O. and L.O. as a family. Generally, L.O. was reluctant to attend the therapy sessions, but did attend on a few occasions. In 1994 and 1995, Respondent saw the various family members, either alone or in groups, a total of 53 and 57 times, respectively. L.O. saw Respondent three or four times in each of those years. Only a few sessions occurred in which all four family members were present. In the course of the various therapeutic relationships, boundaries were blurred, and it was not possible to maintain complete patient confidentiality. For example, in one session, M.O. reported to Respondent that J.O. struck E.O. That incident had not been reported to Respondent by J.O.

14. M.O. subsequently began a reconciliation process with her parents and, in April of 1997, returned to individual psychotherapy with Respondent. She had by then reached the age of majority[7] and was co-habiting with her boyfriend. During her first visit, Respondent asked M.O. to have her mother come with her to her sessions. J.O. was initially reluctant to do so but acquiesced and began coming to the sessions in June or July of 1997. The sessions then involved Respondent seeing M.O. for approximately 15 minutes, J.O. for approximately 15 minutes, and both M.O. and J.O. for the remainder of the time. M.O.'s therapy sessions with Respondent lasted into August of 1998. Although Respondent has only ten progress notes reflecting the therapy sessions between April 1997 and August 1998, M.O. attended more than ten therapy sessions with him. Among the subjects M.O. discussed with Respondent were M.O.'s relationship with her various family members, and her parents' relationship with E.O. When J.O. was alone with Respondent, they discussed whether M.O. had experienced any improvement, L.O.'s input into the family situation, J.O.'s relationship with L.O., and other issues concerning M.O.

15. Respondent's former office administrator testified that she was always present at her desk during M.O.'s visits in 1997 and 1998, and that J.O. never went into Respondent's office alone or with M.O. Rather J.O. would either wait in the waiting room or would leave the office and return later to pick M.O. up. Both J.O. and M.O. testified that J.O. was involved in at least most of the sessions and met Respondent both individually and with M.O. The testimony of J.O. and M.O. is deemed the more credible on that issue for the following reasons:

a. M.O.'s appointments were occasionally at times when the office administrator may have left the office for the day.

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[7] M.O. is now 25 years old.

b. The former office administrator saw several people enter and leave the office each day. She would have less occasion to recall a particular patient six or seven years before, and whether that patient participated in conjoint therapy, than would the patient herself, who had very specific reasons for recalling the details of the visits with Respondent.

c. In 1997 and 1998, M.O. had her own car. If J.O. was not involved in the therapy, she would have no reason to go to the sessions and either wait in the waiting room for them to conclude, or leave and then return at the end of the sessions. Even if J.O. wanted to accompany M.O. to the sessions for the sole purpose of seeing Respondent, albeit briefly before or after M.O.'s session and in a public area (an improbable scenario), M.O. would have no incentive or motivation to permit that to occur, and J.O. would most likely be reluctant to appear at Respondent's office very frequently for fear that M.O. might suspect an ignoble motive on her mother's part.

16. The first time Respondent saw J.O. out of M.O.'s presence in 1997, he told J.O. how good she looked, kissed her on the mouth and told her they could then be friends and could start having lunch together. J.O. had undergone a breast augmentation since last seeing Respondent. Respondent asked to see her breasts. J.O. declined that request.

17. In late 1997 or early 1998, J.O. began seeing Respondent independently of M.O.'s therapy. No appointments were scheduled through the receptionist. Instead, Respondent would telephone or page J.O. and make arrangements to meet at the end of the day, after Respondent's last patient left. The meetings usually occurred in the late afternoon on Fridays and Sundays. The appointments were not placed in Respondent's patient appointment book. No records were kept, and J.O. was not charged for the meetings.

18. E.O. ran away from home in 1998. He saw Respondent for therapy on various intermittent occasions during that year. When he did so, J.O. took him to Respondent's office and the sessions were conducted in the same manner as M.O.'s sessions, with E.O. seeing Respondent first, then J.O. seeing Respondent alone, and finally E.O. and J.O. seeing Respondent together. One such session occurred April 7, 1998, Respondent's birthday. J.O. brought Respondent a birthday card and told Respondent she wanted to give him a kiss for his birthday. While J.O. was alone with Respondent and E.O. was in the waiting room, J.O. and Respondent kissed passionately and Respondent grabbed J.O.'s breasts over her clothes and put his knee between her legs. Respondent achieved an erection, looked down and then said to J.O., "Look what you're doing to me." The April 7, 1998 incident marked the beginning of a sexual relationship between J.O. and Respondent.

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19. Throughout April and May of 1998, the private meetings between J.O. and Respondent continued. The meetings took place exclusively in the therapy room of Respondent's office, and consisted of initial conversation, usually regarding J.O.'s problems with her husband and other members of her family. On at least one occasion, they discussed a friend of J.O.'s husband whom J.O. had kissed, but with whom she had not had a sexual affair. The conversations between J.O. and Respondent were generally followed by kissing and an increasing amount of petting. In May, Respondent asked J.O. to perform oral copulation on him. J.O. refused and Respondent called J.O. a "chicken." At one point, Respondent told J.O., ". . . this is all about you, not me. If it was about me, my pants would be down and you'd be sucking my cock now." In June, Respondent touched J.O.'s breasts under her blouse and placed her hand on his penis over his clothes. In July, Respondent performed cunnilingus on J.O. In September, he placed her hand on his naked penis. By October, Respondent and J.O. were engaging in reciprocal oral sex. On various occasions between April and September of 1998, Respondent told J.O., in very explicit and vulgar terms, his fantasies and desires regarding sexual activity with her.

20. On June 16, 1998, Respondent saw L.O. regarding E.O.'s situation. They also discussed the problems L.O. and J.O. were experiencing in their marriage. They did not discuss any confidentiality issues or whether L.O. was a patient. Although Respondent wrote "informed consent issues discussed" on a progress note for that session, L.O. denies giving informed consent in connection with the various therapeutic relationships the family members had with Respondent, and L.O. does not know what that expression means. Respondent and L.O. did not discuss any issues relating to E.O.'s or M.O.'s privacy, boundary issues, or Respondent's relationship with J.O. The characterization by Respondent and his expert witness of the June 16, 1998 session with L.O. as a "consultation" because it was about E.O. rather than L.O.'s issues was not convincing. L.O. had already treated with Respondent as a patient. E.O. was L.O.'s son. L.O. was involved with and impacted by his son's psychological problems. To consider E.O.'s problems so detached from his father as to render Respondent's June 16, 1998 session with L.O. merely a "consultation" defies both logic and reason. The fact that Respondent and L.O. also discussed L.O.'s marital problems further evidences the nature of the meeting as having been a therapy session rather than a consultation.

21. Respondent did not think it was appropriate or necessary to disclose his social relationship with J.O. to any family member, including M.O., because he considered J.O. to be a former patient. He also believed that, since M.O. saw J.O. and Respondent talking in his office, anything further would be redundant (Respondent's term). Respondent did not think his sexual relationship with J.O. interfered with his objectivity in M.O.'s therapy. He considered himself to be providing a "safe harbor in the storm for the children."

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22. On November 20, 1998, J.O. again met Respondent in his office. They engaged in sexual intercourse. For the previous few months, L.O. had been suspicious that his wife might be having an affair with Respondent and, beginning in August of 1998, L.O. had kept a log of the calls J.O. received on her cellular telephone and pager. On November 20, 1998, L.O. followed his wife to Respondent's office building and, from the parking structure across from the building, he used binoculars and a telescope to look into the window of Respondent's office. L.O. saw his nude wife and Respondent, whose upper body was nude,[8] engaging in sexual activity. On November 29, 1998, L.O. confronted his wife regarding her infidelity, and J.O. admitted to her affair with Respondent.

23. At no time before or during his sexual relationship with J.O. did Respondent attempt to confirm that J.O. had seen or was presently seeing another psychotherapist, either by asking J.O. about it, or by any other means. During their late afternoon meetings in Respondent's therapy room, J.O. believed the first part of their meetings was for the purpose of receiving individual psychotherapy from Respondent rather than simply engaging in casual conversation. She did not perceive the sexual activity that followed their discussions as being part of the therapy. Respondent did not believe that the conversations that preceded their sexual encounters constituted psychotherapy. Respondent never telephoned J.O. again after having sexual intercourse with her. However, during one telephone call J.O. placed to Respondent, J.O. expressed concern over the possibility that she could become pregnant by him since he had not used a condom when they had engaged in sexual intercourse.

24. Despite his sexual attraction to J.O., at no time before or during their sexual relationship did Respondent seek professional consultation concerning his attraction to J.O. and the possible effect the sexual relationship could have on her, the other family members, and/or him.

25. Respondent's conduct with respect to patient J.O. constituted gross negligence, repeated acts of negligence, and corrupt acts, as set forth above.

26. E.O. last saw Respondent in the spring of 1998. M.O. last saw Respondent in August of 1998. Respondent never formally terminated therapy with L.O., M.O. or E.O.

27. Respondent's care and treatment of J.O., L.O, M.O., and E.O., prior to and during the time he was engaging in a sexual relationship with J.O, constituted gross negligence and repeated acts of negligence, as set forth above.

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[8] L.O. could see only the upper part of Respondent's body.

28. L.O. and J.O. subsequently sued Respondent. In approximately November of 1999, the lawsuit was settled for Respondent's payment of $200,000.[9] This matter came to the Board's attention as a result of the settlement. No family member filed a complaint with the Board.

29. J.O. and L.O. divorced in June of 2002. The divorce was acrimonious and, on at least one occasion, L.O. accused J.O. of having stalked Respondent. J.O. became extremely depressed and drank heavily. At one point, L.O. attempted to obtain a restraining order against J.O. because of her aggressive behavior toward him. Emotions have calmed since that time, and L.O. has recanted his accusation that J.O. stalked Respondent, claiming instead that J.O. occasionally drove past Respondent's office. J.O. has reduced the amount of her alcohol consumption, and there have been no additional violent acts. L.O. and J.O. blame J.O.'s affair with Respondent for the dissolution of their marriage. Despite the bitter conflict and marriage dissolution caused by the extra-marital affair between J.O. and Respondent, L.O. and J.O. enjoy a cordial relationship today.

30. During the time Respondent and J.O. were involved in their sexual relationship, Respondent was experiencing some difficult issues in his private life. His 13-year marriage was ending. His parents were both seriously ill, and his father subsequently died. Respondent's brother-in-law was diagnosed with Parkinson's disease, and he became non-ambulatory following a series of strokes.

31. After J.O. and L.O. filed the civil lawsuit, Respondent realized he needed counseling and began seeing clinical psychologist Thomas F. McGee, Ph.D. Respondent underwent the counseling to get a peer's consultation and feedback; to examine his error in judgment fully and aggressively; to see what could be done in his professional and personal life to ensure it would not recur; and to discuss boundary issues regarding J.O. and other patients as well.

32. Respondent began his treatment with Dr. McGee in September of 1999. As of July 14, 2004, he had seen Dr. McGee 29 times. Based on those meetings, Dr. McGee believes Respondent does not constitute a danger to his patients, and that the probability of his having an inappropriate relationship with a patient in the future is "very, very low."

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[9] The settlement of the civil lawsuit is not dispositive of any substantive issue in this administrative disciplinary action. It is referenced as a credibility finding to demonstrate a lack of incentive for J.O. and L.O. to fabricate the events between 1993 and 1998.

33. During the course of therapy, Respondent and Dr. McGee discussed clinical issues in Respondent's practice, personal occurrences that might affect his practice and professional conduct, Respondent's own health issues, boundary issues with patients, and physical relationships, including the importance of "talking it out" with the patient. They discussed the differences between acceptable touching in the therapeutic relationship (i.e., shaking hands with the patient on the initial contact) and inappropriate touching. Respondent accepted some, but not full responsibility for what occurred with J.O. He believed he should have stopped before the touching and hugging started.

34. Dr. McGee explained that, due to boundary and dual relationship issues, a psychologist should have no social, business, financial or sexual contact with a patient. The psychologist must control that aspect of the relationship because patients occasionally want to breach the boundaries. Based on the 29 therapeutic sessions, Dr. McGee believes Respondent now understands those boundary issues.

35. Dr. McGee believes Respondent has profited from his therapeutic experience, continues to monitor his professional demeanor, avoids dual relationships, and is more aware of the personal occurrences that can affect his professional life. Dr. McGee considers Respondent a sensitive, thoughtful and balanced clinician.

36. However, Respondent was not entirely candid with Dr. McGee. He told Dr. McGee that, in summer of 1998, his former patient arrived unannounced, that there was mutual touching and hugging, and that Respondent experienced an unexplainable lapse in judgment. It was a one-time incident and sexual intercourse did not occur. When asked if his opinion would change if he learned that continuing and increasing sexual contact occurred during September, October and November of 1998, and that the sexual contact culminated with sexual intercourse, Dr. McGee stated that he was not sure it would affect his opinion, but that he would want to know why he was not told. It may or may not have raised concerns for him. Dr. McGee acknowledged that, if the facts of the above hypothetical question were true, he might have been misled by Respondent.

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37. At the administrative hearing, Respondent denied several of the allegations made by J.O., which have been found to be true in the factual findings herein.[10] For example, he denied:

a. that he kissed J.O. on the forehead or touched her leg.

b. that J.O. asked to be referred to a female therapist.

c. that he told J.O. he found her attractive.

d. that he asked to see J.O.'s breast augmentation.

e. that he asked M.O. to bring her mother to therapy with her.

f. that J.O. attended any of M.O.'s therapy sessions beginning in 1997.

g. that he suggested to J.O. that they be friends.

h. that he spoke with J.O. about the use of alcohol or drugs, her depression, prior sexual abuse, or family problems, when they would meet in his office before engaging in sexual activity.

i. that he kissed J.O. or touched her in a sexual manner at any time during 1997.

j. that he kissed J.O., squeezed her breast or put his knee between her legs in April of 1998.

k. that he removed J.O.'s clothing and performed oral sex on her.

l. that he had sexual intercourse with J.O.

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[10] J.O. made several other allegations that did not rise to the level of clear and convincing evidence such that they could form the basis for a factual finding, or were not directly relevant to the issues to be decided. Respondent denied those allegations as well.

Throughout a great deal of his testimony, Respondent frequently and repeatedly referred to J.O. as "former patient O____." Yet, he admitted that, between April of 1998 and November of 1998, he saw "former patient O_____" "incidentally," spoke with her by telephone, and formed a "friendship." They met 4-6 times in his office and discussed "what friends normally talk about—inconsequential things," and that there was "sexual contact" between them, consisting solely of kissing, hugging and fondling. He later admitted that they engaged in oral sex, but not to the point of orgasm. He based his denial of sexual intercourse on temporary erectile dysfunction. However, despite that denial, Respondent also admitted that, on a date after November 20, 1998, J.O. questioned him regarding the possibility of his having impregnated her.

38. Respondent also claimed that he always documented in his progress notes the identity of all individuals who were present at a therapy session, except when a parent came in after a minor patient's session. Therefore, he was able to determine when J.O. and M.O. saw him together in 1997 and 1998. Those progress notes must be viewed with caution, however, since Respondent had requested M.O. to bring her mother to the sessions without his offering any genuine purpose for the request, and because, during that time, a sexual relationship developed with J.O., and Respondent had a motive not to document any therapeutic contact with her lest J.O. be viewed as a current patient. Respondent also maintained that the fact that he kept no chart notes for J.O. individually in 1997 and 1998, establishes that she was not his patient at that time.[11] That testimony must also be viewed with caution because, as with his progress notes on M.O., Respondent was motivated to prevent J.O. from being construed as a current patient.

39. Respondent acknowledged that the sexual relationship with J.O. was an "error in judgment" on his part. He was concerned about J.O. even while the relationship was occurring. He did not believe he fell below the standard of care[12] in having the sexual relationship, but acknowledged that he made a "serious error" in participating in it. He claimed the relationship damaged his life and may have damaged other lives as well. Despite J.O.'s dependence on and belief in Respondent, Respondent believes the transference in her therapy was "little and well-managed." Despite his attraction to J.O. that led him to have an extra-marital affair with her, he believes there was "very little" counter transference with her, and that they both "pretty much stayed on track and dealt with her issues." Respondent recognized that he had to be especially careful of counter transference in J.O.'s case because it was a complex case, and because he was treating multiple family issues.

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[11] Respondent also mentioned a lack of other indicia of a therapist/patient relationship such as payment for services and an understanding between a patient and therapist that therapy will occur and what will occur in the therapy. The fact that J.O. believed that she was in therapy in 1997 and 1998, while Respondent harbored no such belief, evidences the extent to which the therapeutic boundaries had been blurred by that time.

[12] That testimony is inconsistent with Respondent's testimony referenced in Paragraph 41, below.

40. Respondent testified that a lot of planning was done for M.O. in connection with her therapy because it was important, especially with an adolescent, to establish with the patient what confidentialities would be maintained and what must be disclosed to her parents. That extensive planning is not reflected in Respondent's chart. Respondent also testified that he discussed with the children whether they had feelings about him being the therapist for both of them; that L.O. and J.O. were clear that they wanted him to conduct the therapies; and that he was comfortable managing the family relationships. Therefore, although he discussed the issues of multi-patients with the family members, he did so only to what he considered an appropriate extent, and he did not discuss the complexity of those issues with them. Yet, despite all of that planning, reflection and discussion, Respondent did not disclose to L.O., M.O., or E.O., the "friendship" he was having with their wife/mother while he was in a therapeutic relationship with them.

41. Respondent admitted that, in his opinion, his relationship with his former patient progressed to the point that he fell below community standards, and that "friendly relationships with former patients that were role-definite" were below the standard. However, he was unable to define the community standard at that time because he has seen so many permutations of such social relationships, although, at that time, there existed a community standard against such relationships within two years of therapy termination. Nonetheless, his own professional standard was breached by the role-definite relationship. When asked on cross-examination whether he considered the kinds of harm he might do to the former patient with a sexual relationship, he was only able to explain that, in the beginning of that relationship, J.O. seemed intact and functioning well; that he thought she was in therapy with someone else (although he did not provide the basis for that belief); and that he was not focused on J.O.'s earlier therapy, which was part of his "error in judgment." Respondent considered his "error in judgment" to be allowing the relationship to go forward.

42. It was difficult to place a great deal of credibility on much of Respondent's testimony because he tended to answer questions evasively, or would fail to answer a question directly and instead, seemed to respond to a different, unasked question. This pattern of response conduct was especially noticeable on cross-examination, but also occurred, less frequently, on direct examination.

43. Respondent offered the testimony of three former and/or present patients, all of whom portrayed him as a caring and competent mental health care provider who had exhibited proper ethical conduct with them at all times. They also corroborated Respondent's practice of seeing a minor patient first, then the parent(s), and then minor patient and parent(s) together during a therapy session.

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The Standard of Care

44. Complainant offered the expert witness testimony of Veronica A. Thomas, Ph.D., a sole practitioner in clinical and forensic psychology, and a lecturer in abnormal psychology at the University of California at Irvine. Among the opinions Dr. Thomas expressed were the following:[13]

a. Frequently patients feel dependent on the therapist and seek his approval. When they sense that their feelings will not be reciprocated, it should be addressed in therapy. J.O. had symptoms of borderline personality disorder. Possible borderline personalities engage in secretive behaviors. Such patients lack boundaries and have trouble defining relationships appropriately. Sometimes, borderline personalities who have been abused can be seductive and relentless.

b. When J.O. started treating while M.O. was treating between 1993 and 1996, Respondent was treating two family members without indication of the primary patient's identity. Since the goal of therapy was to develop an appropriate transference, Respondent should have referred J.O. to another treating mental health care provider.

c. It is not necessarily below the standard of care to work with families and occasionally to have sessions with individual family members. However, if that is done, it must be reflected in each patient's chart. In this case, because of J.O.'s psychological vulnerabilities, her issues were separate from those of the family. As a family therapist, Respondent must have identified the issues the entire family would address together. It would have then been appropriate for J.O. to participate in the family therapy sessions. However, it is difficult, and in this case, was impossible, for the therapist to maintain his objectivity when the family members were "pigeon holed" into individual therapy. Family therapy addresses the family's goals. If a member needs individual therapy, he/she should be referred out.

d. The conflict in treating an individual while doing family therapy is that the therapist cannot provide complete objectivity and undivided professional attention and guidance. Psychologists are trained to recognize the problem and, if well trained, can deal with the conflicts and work through them. If that is done, the therapy may proceed. However, in this case, it appears that the family therapy was devolved largely into individual therapy.

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[13] Not all of Dr. Thomas's opinions are listed below. Some of those that had little or no relevance, and some of those based on unproven matters are omitted.

e. Family members reporting various things to Respondent, such as M.O.'s telling him that J.O. was treating with another health care provider, evidences the problem with treating multiple family members. The family members reporting various things to Respondent helped to contribute to the "muddiness" of the therapeutic relationships. Eventually, Respondent lost his objectivity and became sexually involved with J.O. The relationship then became one of communications between two intimates instead of between doctor and patient.

f. Respondent's asking M.O. to speak to J.O. about participating in M.O.'s therapy in 1997, and J.O.'s subsequent return, made J.O. a patient again. With J.O. being a trauma patient without a separate therapist to deal with her own transference,[14] it caused psychological difficulty and confusion for the patient. It was a professional therapeutic interaction for J.O. to see Respondent at the end of and in connection with M.O.'s therapy sessions. Respondent's conduct in that regard was grossly negligent because M.O.'s psychological needs became secondary to interaction between Respondent and J.O.

g. If Respondent spoke with J.O. after M.O.'s therapy sessions in 1997 and 1998, his chart should have so indicated. Each of the family members needed treatment by individual treaters to guarantee objectivity. They needed informed consent to determine the identity of the family member Respondent viewed as the primary patient. Respondent's failures to observe those requirements constituted extreme departures from the standard of care in that every one of the family members was being professionally neglected with respect to their individual needs.

h. Respondent's kissing J.O., asking to see her breast augmentation, and proposing that they be friends while J.O.'s daughter was in therapy, blurred the boundaries and constituted an extreme departure from the standard of care. J.O. was very disturbed in connection with relationships. A trauma patient, such as J.O., is much more likely to be damaged by inappropriate boundaries because it causes a re-injury of the original injury.

i. In July of 1997, one month after Respondent asked J.O. to see her breast implants and offered to be her friend, Respondent discussed with M.O. her report that her mother was upset. This was an extreme departure from the standard of care.

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[14] The terms "transference" and "counter transference" were used on several occasions during the course of the hearing and were defined in similar but slightly varied ways by various witnesses. Authoritative definitions of those terms are contained in Stedman's Medical Dictionary (27th ed. 2000) as follows: "transference . . . 3. Displacement of affect from one person or one idea to another; in psychoanalysis, generally applied to the projection of feelings, thoughts, and wishes, onto the analyst, who has come to represent some person from the patient's past." (*Id.* at p. 1861.) "countertransference . . . In psychoanalysis, the analyst's transference (often unconscious) to the patient of emotional needs and conflicts from the analyst's past experiences or the analyst's current emotional responses to the manifestation of the patient's transference." (*Id.* at p. 420.)

j. The conversations between Respondent and J.O. in 1997 and 1998 constituted a continuation of J.O.'s earlier therapy even though the sessions were informal. Respondent and J.O. arranged to talk professionally. She trusted him and took his advice. There was a strong transference relationship that had been unresolved by the earlier therapy termination. Respondent's seeing J.O. in that manner was an extreme departure from the standard of care. Respondent had many opportunities to be objective and to assess the potential problem areas with the relationship, but failed to do so.

k. Respondent's seeing L.O. and E.O. complicated matters because they were additional family members creating more intimate relationships for Respondent, who was already interacting with other family members (J.O. and M.O.). Like M.O., E.O. was subjected to the same treatment of J.O. seeing Respondent after E.O.'s sessions, so there was more confusion as to the identity of the primary patient. Respondent was unable to define his role and maintain his objectivity.

l. From a psychological standpoint, touching becomes sexual when the therapist's counter transference issues override the interests of the patient. The therapist has power over the patient. When his/her feelings become sexualized or could be interpreted as such, the patient becomes exploited and "the train is off the track" (Dr. Thomas's term). It can occur without the therapist even being aware of it.

m. Respondent's conduct was the dishonest and corrupt behavior of a sexual predator. J.O.'s initial consultation with Respondent was about J.O.'s daughter. Later, Respondent noticed that J.O. was depressed and recommended a course of psychotherapy for her. J.O. shared her background of being a sexual abuse victim with him. A relationship of trust and dependency developed normally. Respondent saw J.O. as vulnerable, isolated her in a personal relationship that involved her family and caused her to question her own feelings. There was ongoing desensitization of J.O. to Respondent's sexual feelings toward her and eventually, he took advantage of her vulnerability and had sex with her. It would be consistent for a patient with J.O.'s history and presentation to be an adulteress. Such individuals often have relationships with several people and tend to be substance abusers. That is why they are psychotherapy patients. There is no indication that J.O. was treated as a trauma patient should have been treated. If J.O. came to a session without underwear or in alluring dress as Respondent claimed, it should have been more obvious to Respondent that she was the type of patient who was particularly vulnerable and at risk, and it should have raised a therapy issue in Respondent's mind. Respondent should have questioned J.O.'s motives within the family therapy context and asked what she was trying to tell him by her attire. It was professionally inappropriate for Respondent to fail to professionally address the alleged conduct and attire.

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n. With every sexual encounter between Respondent and J.O., the degree of patient damage increased. Respondent failed to provide helpful treatment and J.O. became desensitized to sexual assault. It is understandable that J.O. would be confused about whether she was just there to chat or for therapy. Patients such as J.O. need safety in relationships. Saying "Look what you're doing to me" is significant to a trauma patient. Respondent and J.O. were not normal adults. They were doctor and patient. Respondent told his patient it was her fault that he was getting an erection. These were extreme departures from the standard of care.

o. Respondent's comment that it was about J.O. and not about him is significant in that it shows that J.O. was a patient and that the sexual behavior was supposedly for her own good. For a sexual abuse patient, that was particularly damaging because her therapist should not be inflicting "sexual pain" on her. His challenge of her unwillingness to get on her hands and knees and perform oral sex on him was also significant in that it shows that, despite his claim to the contrary, the sex was for him. Respondent's conduct constituted a "very extreme departure" from the standard of care.

p. It was grossly negligent for Respondent to engage in sexual intimacies with a patient. The intercourse was an extraordinary boundary failure. Respondent inflicted on his trauma patient the same kind of betrayal with which another trusted person in her life had previously victimized her. Respondent's behavior constituted sexual abuse which occurred during the course of a transference relationship. By engaging in a sexual relationship with J.O., Respondent abdicated his responsibility to take care of J.O. and to cause her no harm.

q. The standard of care prohibits any kind of a personal relationship with a former patient for two years following formal termination of therapy. That is a no-contact, "cooling off period" during which the psychologist must take action to ensure that no harm will come to the patient if a sexual relationship occurs. The psychologist must show that there was no exploitation during the relationship and that the therapeutic relationship was not terminated in order to commence a sexual relationship. The psychologist must refer the patient to another therapist to ensure a lack of remaining transference problems. The patient must understand the therapeutic relationship is permanently over. The patient's personal history is another factor the therapist must take into consideration. He/she must decide if the patient's history was attractive to him/her and whether that attraction interfered with his/her doing what was best for the patient. However, that does not mean that any patient and any psychologist may have a sexual relationship after two years of therapy termination. For example, the effect on family members must be considered if family therapy was occurring. The psychologist must, at all times, put the patient's best interests first. These are very complicated issues, and some situations cannot be sufficiently resolved so that a sexual relationship between a therapist and a former patient would not harm the patient.

r. No particular date or time exists for a sexual relationship with a former patient to commence following the two-year period after termination of therapy. The nature of the therapeutic relationship is intense. The transference relationship is one of dependency of the patient on the therapist. Depending on the kinds of issues in treatment, the transference relationship may take a long time to resolve. There must be an establishment of no harm to the patient. Thus, the therapist may want to refer the former patient to a third party therapist to assess the possibility of patient harm in a sexual relationship with her former therapist. The former therapist may also seek help for counter transference issues. The American Psychological Association (APA) provides guidelines in this area.[15] In this case, a sexual relationship between Respondent and J.O. would never have been appropriate regardless of the amount of time that passed after J.O. left therapy because of the nature of J.O.'s psychological problems and issues, the ongoing professional relationships Respondent had with J.O.'s family members, and J.O.'s dependence on Respondent throughout the course of the relationship. J.O. had placed herself in Respondent's emotional, physical, and psychological care, and was too psychologically frail to take on a healthy physical relationship with Respondent.

s. The types of patients most likely to be damaged through post-therapeutic sexual relationships with their former therapists are people with serious Axis I diagnoses,[16] those on medication, borderlines, and victims of abuse. Such patients are extremely fragile.

t. J.O.'s symptoms were consistent with borderline personality disorder. An individual with that personality disorder has trouble making attachments with people and, when they detach, the other person can be viewed as an enemy. An individual with borderline personality disorder can be vengeful and stalking. He/she may be physical aggressive when stressed, and may have substance abuse problems.

u. Alcoholics do not lie more than the general population. Denial is characteristic of the general human condition. It is not limited to alcoholics.

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[15] The APA's guidelines were not offered for, and are not considered as having the effect of law. They were considered by Dr. Thomas as only one factor in determining the standard of care in this case.

[16] "Axis I" refers to any functional disorder referenced in the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders, (DSM-IV) published by the American Psychiatric Association.

v. Based on her descriptions, J.O. was an individual who was at high risk for a post-therapeutic sexual relationship with her therapist. She had complete trust in Respondent and was completely dependent on him. She was not strong enough to make independent decisions about her behavior. For J.O. to have sex on Respondent's couch as a former patient was disorienting to her. She had fluid, inconsistent boundaries and could not understand the beginning and end of relationships. She did not understand boundaries and had been abused by other professionals. The setting for the sexual intimacies was significant. Professional things had happened in Respondent's office and the sexual contact was not professional in nature. That confused J.O. and recapitulated what happened to her at the hands of other professionals. The late afternoon time for the 1997 and 1998 appointments was also significant. J.O. trusted Respondent and engaged in sexual acts because she believed he was doing what was best for her. Respondent's conduct was a violation of her vulnerability.

w. Even if no conversation took place in the 1998 meetings before Respondent and J.O. engaged in sexual intimacies, the meetings were nonetheless inappropriate and constituted a "session" because a powerful unresolved transference relationship still existed even after the therapy terminated in 1996. Therefore, the sexual relationship was harmful to J.O. They met on Respondent's "turf" (his office) at an appointed time. Whatever the nature of their conversations, they were based on the psychologist's power and strength.

x. Even absent a statute prohibiting having a sexual relationship with a former patient, it is the psychologist's duty to do that which is in the former patient's best interests and to ensure that no harm will be done to the former patient by entering into a sexual relationship. In certain cases, the psychologist must eschew a sexual relationship with a former patient entirely because harm cannot be avoided. In this case, J.O. was a trauma victim who was not in a position to distinguish between Respondent as her psychologist and Respondent as her paramour. She felt completely dependent on Respondent and trusted everything he did. It was incumbent on Respondent to take all factors into consideration before entering into a sexual relationship with J.O. He failed to do so. Respondent's engaging in sexual relations with J.O. was "downright damaging" (Dr. Thomas's term) for a patient with her psychological history and composition, and was well below the standard of care.

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y. L.O. could not be seen on a consult basis because he was Respondent's patient. A consult involves an individual who "walks in off the street" and seeks a consultation on a particular issue. Matters discussed in the June 16, 1998 "consultation" regarding anger between E.O. and J.O. raised standard of care issues because Respondent was unable give an objective opinion since he was simultaneously seeing L.O., E.O. and J.O. In addition, the June 16, 1998 "consultation" occurred approximately one week after Respondent first removed J.O.'s blouse. If informed consent issues were discussed, they necessarily would have to include a discussion regarding the nature of Respondent's relationship with L.O.'s wife, and other issues adverse to a professional relationship with L.O. Otherwise, the informed consent discussion would be a dishonest and corrupt act. The manner in which Respondent dealt with the June 16, 1998 "consultation" with L.O. constituted an extreme departure from the standard of care.

z. The same problem was raised regarding informed consent issues for M.O. in 1998. Respondent was engaged in sexual activity with his patient's mother, and his ability to provide competent treatment to M.O. was compromised by his relationship with J.O. M.O. was in crisis and Respondent was unable to help her. Respondent's courses of conduct, as described in subparagraphs "y" and "z" constituted extreme departures from the standard of care.

aa. Respondent did not and could not maintain separate and distinct therapy relationships with each of the family members, and therefore, he was unable to competently address each family member's individual and distinct problem areas. Each family member's problems were related to those of other family members, and the various problem areas were substantial in scope. As Dr. Thomas wrote:

> The problem areas were so great as to include JO's physical abuse of EO, MO and EO's use of illicit substances, problems with the older son TO, JAO's depression over her marriage, EO running away from home, and JAO's use of alcohol. Additionally, during the time that MO came back to therapy as an adult, Dr. Siegel was seeing JO separately for "informal" therapy sessions. The treatment notes involved all parties and their interrelationships with one another. As I indicated during my testimony at trial, it is not possible to provide for each person's individual needs under these circumstances and there were multiple opportunities to reflect upon the situation and take remedial action. Dr. Siegel failed to reflect upon the progress made, or lack thereof; examine what factors might be contributing to problem areas, including those within himself, and make necessary informed consent decisions with the family members regarding privacy and boundary issues, treatment goals and treatment adjustments.
> (Declaration of Veronica A. Thomas, Ph.D., Complainant's Exhibit 19, p. 1.)

bb. Dr. Thomas further opined that, "The severe degree of problems in the family made separate and distinct therapy relationships impossible." (*Id.* At p. 2.)

cc. Despite Respondent's testimony and notes in his charts that he discussed informed consent issues with the family members and obtained their informed consent, Dr. Thomas opined that the informed consent issues he may have discussed with them were insufficient under the circumstances. Dr. Thomas wrote that her opinion

> . . . is based upon my review of the case file and typewritten treatment notes that fail to demonstrate informed consent of the family members with regard to the potential confidentiality and privacy problems associated with seeing multiple parties in one family; there is no indication that the adolescent patients were informed of this or that they were capable of understanding the potential impact of being in therapy with Dr. Siegel while their mother and father were also being treated. Informed consent would have made clear prior to treatment that JAO's eventual physical assault on EO as reported by MO would have had to be reported to authorities. Informed consent for LO's consultation would have indicated to him that JAO and EO were already in treatment with Dr. Siegel and could affect his ability to be objective with regard to LO's problem area at time of consultation. With Dr. Siegel's level of understanding regarding the serious problem areas of these family members, treating them as he did caused serious problems for this family.
> (*Id.* At pp. 1-2.)

dd. Respondent should not have continued to treat family members while having a personal relationship with J.O. The primary relationship between patient and doctor is of "immense importance." Anything less dilutes the therapeutic relationship.

ee. The interests of Respondent's patients, and the interests of J.O., were subordinated under Respondent's interests. Everyone was there for Respondent's benefit. Putting his interests before those of his patients was an extreme departure from the standard of care.

45. Respondent offered the expert witness testimony of Paul S. D. Berg, Ph.D., a psychologist working in both the clinical and forensic arenas. Dr. Berg is certified with the American Board of Family Psychology and the American Board of Vocational Experts. Dr. Berg practices in Oakland, California. He estimated he has testified in court as an expert witness more than 1,000 times.

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46. Among the opinions Dr. Berg offered were the following:[17]

a. When faced with the complexities of treating family members in family therapy and individual therapy, those issues should be discussed with the patients at the outset, not when they come up. Dr. Berg did not see anything to indicate that Respondent had discussed those complexities with the family members.

b. The decision whether to treat multiple family members is a clinical one to be made by the clinician. Undertaking treatment of several family members does make the relationships more complicated and therefore, there must be a reason to undertake it. The undertaking should be avoided if one wants to practice "antiseptically" (Dr. Berg's term). However, treating more than one family member can have a beneficial effect where family dynamics are so complex, they can use their disparate therapies to their own advantages. Being referred out can be construed as rejection by the therapist.

c. Informed consent does not change as the patient's therapy changes. The concept of changes to informed consent in ongoing therapy does not change the standard of care because it is too difficult to determine what constitutes a change in therapy.

d. If Respondent saw J.O. and L.O. in marital therapy and then saw L.O. in individual session, it was not incumbent on Respondent to define the identity of the primary patient on each visit, but it would be helpful.

e. "Grooming" (occasionally called "rehearsal") occurs when a person with a secret agenda to initiate a sexual relationship at some future time, prepares or "grooms" the intended victim by orchestrating antecedent events. Grooming did not occur in this case. In fact, certain behaviors by Respondent were inconsistent with grooming. For example, Respondent involved a "rival," J.O.'s husband, in the therapy; he referred J.O. to a physician for medication, thus giving her the opportunity to discuss her situation with another professional; and he referred J.O. to a support group for victims of clergy abuse.

f. It is permissible for a psychologist to occasionally touch a patient. The legitimacy of the touch depends on the psychologist's motives, the nature of the relationship, and what is occurring in the therapy at the time. It also depends on the kind of touching that is occurring. Any kind of touching of a sexual nature, or touching that is motivated to satisfy the therapist, should never occur with a patient. Acceptable touching is casual and supportive, such as touching a hand or shoulder or a brief hug. The acceptability of the conduct is on a continuum. Touching should not be a regular part of therapy.

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[17] The same caveat applies to this paragraph as did to Paragraph 44 with respect to the recitation of the experts' opinions.

g. To hold the hand of a patient who recently lost a family member is not below the standard of care. It is a human response the avoidance of which could be construed by the patient as cold and uncaring, and thus "anti-therapy." However, such contact is "fraught with peril today."

h. The "chatting" that occurred between Respondent and J.O. in 1997 when J.O. was in the office with M.O., did not make J.O. Respondent's patient. No notes were made and J.O. was not charged for Respondent's time. Even if J.O. discussed M.O.'s issues, she did not discuss her own; and therefore, she was not Respondent's patient. It was "casual contact" and Respondent's conduct was not below the standard of practice. The same was true in November of 1997 when J.O. brought E.O. to therapy.

i. In order to re-establish a therapy relationship with a former patient, there should be some agreement and informed consent, some memorialization of them, and the establishment of a billing system.

j. For J.O. to have been a patient when she came in with M.O., she would have needed to address her own issues with Respondent and the appointments would need to have been for her.

k. J.O. was not Respondent's patient between August and November of 1998. A patient is an individual awaiting treatment or under care. In order to be considered a patient, an agreement should be in place for ongoing care, there must be "quid quo pro," and the therapist must keep therapy records. In this case, there was no ongoing therapeutic relationship, nor was one anticipated. Had such a relationship existed, it would have tolled the two-year cooling off period. Respondent's sexual involvement with J.O. was "ill advised" but not "against the law."

l. It is permissible for a therapist to be involved in a friendship with a former patient. Consideration should be given to the patient and what the therapist knows about him/her. It may or may not be good judgment to engage in the friendship.

m. There are no exceptions to the two-year guideline for a psychologist having a personal relationship with a former patient because to have such exceptions would be "vague and unenforceable." J.O.'s therapy ended in August of 1996. If, in 1997, J.O. was a former patient with whom Respondent engaged in frank sexual touching, that conduct would fall below the standard of care because it was within the two-year cooling off period. However, if the sexual touching occurred after the two-year period, it would not be below the standard of practice.

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n. If formal therapy with J.O. ended in August of 1996 and Respondent kissed J.O. on the mouth in June of 1997, Respondent would not have deviated from the standard of practice because no standard of practice existed once the therapeutic relationship terminated.[18] However, that conduct would be "frowned upon"[19] by the psychological community.

o. If, in 1997, Respondent saw J.O. privately at pre-set times for her problems in what was essentially a psychotherapeutic relationship, and intentionally kept her off the books by not keeping a chart or billing her, Respondent would have deviated from the standard of care. If the relationship was not essentially for psychotherapy, the relationship between Respondent and J.O. would constitute a friendship and would not violate the standard of care. However, most practitioners would "frown upon it." These opinions were based on Dr. Berg's "sense of what the psychological community believes."

p. No standard of care issues would be raised if Respondent saw J.O. after E.O.'s sessions because J.O. was not Respondent's patient at that point. However, that conduct would be "frowned upon."

q. If, in May of 1998, Respondent placed his hand under J.O.'s bra, that conduct would not constitute a deviation from the standard of practice. It would, however, represent bad judgment and the psychological community would "frown on it."

r. If a therapist terminated therapy with a patient without an intent of a sexual relationship, and started seeing the former patient romantically one week later, that conduct would represent poor judgment but would not fall below the standard of practice. A community standard exists and most practitioners would "frown on it" but there is no law against it.[20]

s. If the sexual relationship between Respondent and J.O. occurred as alleged, the psychological community would "frown upon" the sexual activities and consider it inappropriate even if J.O. were a former patient. If the sexual relationship occurred while J.O. was a patient, it would "very likely" rise to the level of gross negligence.

t. It is arbitrary to consider a former patient's psychological make up in deciding when to have a sexual relationship with her. It is something to consider but it must be decided on a case by case basis.

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[18] This opinion conflicts with Dr. Berg's opinion referenced in subparagraph "m," above.

[19] All expressions of "frowned on," "frowned upon," "frowning upon," and the like are those used by Dr. Berg during his testimony.

[20] This opinion is inconsistent with that in subparagraph "m," above.

u. If J.O. terminated therapy in 1996 and was suicidal, it would be below the standard of practice to initiate a relationship with her about one week later.

v. Dr. Berg could not determine a specific point at which it would have been appropriate for Respondent to have commenced his relationship with J.O. subsequent to the termination of J.O.'s therapy with Respondent. That decision was a matter within the therapist's discretion.

w. If L.O.'s last conjoint visit with J.O. and Respondent occurred in 1995, then the 1998 consult was with a former patient and no therapist/patient relationship existed at that point. It was appropriate for Respondent to discuss the family with L.O. at that point and to make recommendations of what L.O. could do with his son. For L.O. to have been a patient in June of 1998, he would have needed to address his own issues in the session with Respondent, and Respondent would have had to identify him as a patient.

x. Subparagraph 12(D)(h) of the First Amended Accusation reads: "Despite the continued dysfunction in the O[_____] family, he failed to: reflect on the therapeutic progress made, or lack thereof; examine what factors might be contributing to problem areas, including those within himself; and make necessary informed consent decisions with the family regarding privacy and boundary issues, treatment goals, and treatment adjustments." In addressing those allegations, Dr. Berg wrote:

> The aspect of subsection (h) that refers to his failing to look within himself asks other practitioners and regulators to read his mind and his motives, a task that is notoriously perilous and thereby based on second guessing and confabulation.
> (Declaration of Paul S. D. Berg, Ph.D., Respondent's Exhibit "GGG," p. 5, paragraph 14.)

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y. Dr. Berg further opined:

15. The subsection also accuses Dr. Siegel of failing to reflect on therapeutic progress, examine problem areas, indicate treatment goals and treatment adjustments. This is clearly and patently false. His notes contain frequent references as to his treatment goals, his planning, the evaluation of progress and efficacy, even as seen in the early notes of 1993 and 1994 in the treatment of M.O. and E.O. Even in the few conjoint sessions with J.O., there are references to treatment goals and to planning and in fact to lack of progress.

16. The lack of logic in that aspect of the accusation that suggests that Dr. Siegel attempted to "isolate" J.O. for his own nefarious motives is seen in the fact that it is exactly the opposite of the accusation that he used family members to get to each other. It is difficult to know how one engages in these two opposing and contradictory "strategies" at the same time, isolating, and yet simultaneously encouraging interaction.

17. Furthermore, the concept of isolation which I believe does occur in cases of entrapment or seduction is belied by the many referrals he made. For example for the treatment of J.O. he made one referral, reflected in this [*sic*] notes for her to go to a psychiatrist to be evaluated for medications. He made two referrals as well for her to contact a network that specialized in treating people who had been [*sic*] sexual molest victim histories; one of these references also appears in his notes. In fact J.O. is reported to have followed up with one of those sex molest referrals and attended several sessions. People who are trying to isolate or mind control or make mental prisoners of their patients do not encourage them to have contact with outside practitioners for fear that their evil motives would be discerned by another trained practitioner and that they will therefore be exposed.
(*Id.* at pp. 5-6, paragraphs 15-17.)

z. Respondent committed a simple departure from the standard of care for all of his sexual contact with J.O. as a former patient.

aa. Respondent did not commit any extreme departures from the standard of care in connection with J.O., L.O., M.O., and/or E.O., or any "truly unprofessional behavior." "Frowning upon" a course of conduct does not amount to an extreme departure from the standard of care.

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47. As is more fully discussed below, for reasons grounded in law rather than psychology, J.O. is deemed to have been a former patient at the time she engaged in a sexual relationship with Respondent. With that exception, on balance, the testimony of Dr. Thomas is deemed substantially more credible than that of Dr. Berg for the following reasons:

a. On direct examination, Dr. Berg testified as follows: (1) On three or four occasions, he had written reports for the Board of Psychology after assessing cases in connection with possible disciplinary matters. (2) That work was not listed on his curriculum vitae because he did not list every entity that retains him. (3) However, he last worked for the Board four or five years ago, and first worked for the Board a few years before that time. (4) The work he performed for the Board was done at the request of another expert whom the Board had retained. Dr. Berg's testimony in that regard was belied by that of Kathi Burns, an Enforcement Coordinator for the Board. Ms. Burns checked the Board's expert witness list and its payment records, and checked with the cashier at the Department of Consumer Affairs to determine if any payment had ever been made to Dr. Berg. She found no evidence of Dr. Berg ever having performed any kind of services for the Board. In addition, the Board has never retained an expert by sub-contracting through a different expert who was on the Board's list of approved experts. Dr. Berg is deemed to have been willfully false in his testimony regarding his purported experience as an expert for the Board. Accordingly, his entire testimony may be rejected. (*Nelson v. Black* (1954) 43 Cal.2d 612, 613 [275 P.2d 473].)

b. Dr. Berg seemed unable to accurately define the standard of care, reiterating several times that, although Respondent did not deviate from the standard of care with respect to various acts and/or behaviors, those acts and/or behaviors would be "frowned upon" by the psychological community. "[T]he standard for professionals is articulated in terms of exercising 'the knowledge, skill and care ordinarily possessed and employed by members of the profession in good standing . . .' (Citation). (*Flowers v. Torrance Memorial Hospital Medical Center* (1994) 8 Cal.4th 992, 998, [35 Cal.Rptr.2d 685].) Dr. Berg failed to explain how the psychological community "frowning upon" a course of conduct represents something other than the individual whose conduct is disapproved of having deviated from the standard of care. He also failed to define what was meant by a course of conduct being "frowned upon" except by what it is not. (As indicated above, Dr. Berg does not believe that "frowning upon" a course of conduct represents an extreme departure from the standard of care.) Dr. Berg's failure to appropriately evaluate Respondent's conduct against the standard of care renders his opinions of limited value.

48. Despite the findings in paragraph 47, above, Dr. Berg's testimony is not entirely disregarded. However, it is given substantially less weight than that of Dr. Thomas.

49. On cross-examination of Dr. Thomas, Respondent emphasized an opinion that Dr. Thomas expressed in her written report to the effect that the illegibility of Respondent's progress notes may have been intentional and done for the purpose of "misrepresenting the unprofessional nature of the treatment that was being provided." (Complainant's Exhibit 11, p. 15.) That opinion was not supported by the evidence and, during closing argument, Respondent argued that on that basis, Dr. Thomas could not be believed. Respondent's argument in that regard was not convincing. Although a trier of fact may reject the testimony of a witness, including an expert witness, even if it is uncontradicted (*Foreman & Clark Corp. v. Fallon* (1971) 3 Cal.3d 875, 890), he/she need not reject the expert's entire testimony simply because one part of his/her opinion was not substantiated. The trier of fact may "accept part of the testimony of a witness and reject another part even though the latter contradicts the part accepted." (*Stevens v. Parke Davis & Co.* (1973) 9 Cal.3d 57, 61.) He/she may also "reject part of the testimony of a witness, though not directly contradicted, and combine the accepted portions with bits of testimony or inferences from the testimony of other witnesses thus weaving a cloth of truth out of selected available material." (*Id.* at 67-68.) As indicated above, her opinion regarding the motive behind Respondent's illegible progress notes notwithstanding, Dr. Thomas's testimony is otherwise deemed credible.

Costs

50. Pursuant to Business and Professions Code section 125.3, Complainant's counsel requested that Respondent be ordered to pay to the Board $18,464.68 for its costs of investigation and prosecution of the case. The costs consist of $1,979.68 for investigative services, $580.00 for transcriptions, $2,025.00 in expert witness fees, and $12,880.00 in Attorney General fees.

51. Absent any evidence to the contrary, Complainant's costs of investigation and prosecution are deemed just and reasonable. Although Complainant did not prevail on the first two causes for discipline relating to sexual abuse, misconduct and/or relations, the investigation and prosecution with respect to those causes for discipline was not materially different from that required for other causes for discipline such as the fourth cause for discipline (gross negligence, pursuant to section 2960, subdivision (j)). Therefore, no offset for unproven matters is awarded. Complainant shall recover costs of investigation and prosecution totaling $18,464.68.

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LEGAL CONCLUSIONS

Pursuant to the foregoing Factual Findings, the Administrative Law Judge makes the following Legal Conclusions:

1. Cause does not exist to revoke or suspend Respondent's certificate, pursuant to Business and Professions Code section 726, for sexual abuse/misconduct/relations with a patient, as set forth in Findings 6 through 25, and 44 through 49.

2. Cause does not exist to revoke or suspend Respondent's certificate, pursuant to Business and Professions Code section 2960, subdivision (o), for sexual abuse/relations/misconduct substantially related to the practice of psychology, as set forth in Findings 6 through 25, and 44 through 49.

3. Cause exists to revoke or suspend Respondent's certificate, pursuant to Business and Professions Code section 2960, subdivision (n), for corrupt acts, as set forth in Findings 6 through 25, and 44 through 49.

4. Cause exists to revoke or suspend Respondent's certificate, pursuant to Business and Professions Code section 2960, subdivision (j), for gross negligence, as set forth in Findings 6 through 27, and 44 through 49.

5. Cause exists to revoke or suspend Respondent's certificate, pursuant to Business and Professions Code section 2960, subdivision (r), for repeated acts of negligence, as set forth in Findings 6 through 27, and 44 through 49.

6. Cause exists to order Respondent to pay the costs claimed under Business and Professions Code section 125.3, as set forth in Findings 50 and 51.

Sexual Abuse, Relations, and/or Misconduct

Pursuant to section 2960.1, if Complainant prevailed on the first cause for discipline by proving a violation of section 726, the Administrative Law Judge would be required to order revocation of the license. Further, the Administrative Law Judge would be without discretion to stay the revocation.

Section 726 states in pertinent part:

> The commission of any act of sexual abuse, misconduct or relations with a patient, client, or customer constitutes unprofessional conduct and grounds for disciplinary action for any person licensed under this division, under any initiative act referred to in this division and under Chapter 17 (commencing with Section 9000) of Division 3.

Whether Respondent is subject to discipline pursuant to section 726 depends on whether J.O. was a patient at the time she and Respondent began their sexual relationship in April of 1998. Dr. Thomas made a compelling argument that, from a psychological standpoint, J.O. became a patient again when she returned to Respondent in 1997 in connection with M.O.'s second course of therapy. Certainly, a strong case could be made for J.O.'s being considered a patient in 1998 if for no other reasons than the meetings between Respondent and J.O. occurred only in Respondent's office at the end of his working day; their meetings occurred on a more or less regular basis on pre-scheduled days; their meetings each took approximately one hour; and their meetings entailed discussion as well as sexual activity. Nonetheless, Complainant failed to establish that the conversations between J.O. and Respondent that preceded their sexual encounters were actually therapeutic in nature, and the applicable law is at variance with that interpretation.

Poliak v. Board of Psychology (1997) 55 Cal.App.4th 343 [63 Cal.Rptr.2d 866] involved an individual who had treated with a psychologist, and had terminated treatment after therapy boundaries were blurred by inappropriate touching and contact outside of therapy, leading progressively toward a personal relationship between psychologist and patient. After the therapeutic relationship ended, the psychologist and former patient continued to see each other socially, and engaged in sexual relations approximately 7.5 months after the therapeutic relationship ended. The Court was faced with the issue of whether violations of sections 726, 2960, subdivision (j), and 2960, subdivision (o), applied in such a situation where the sexual relationship occurred after the therapeutic relationship had terminated. The court accepted the definition of "patient" contained in Webster's New Collegiate Dictionary (1977, page 840) which states, "an individual awaiting or under medical care and treatment." After extensive further analysis, the Court then ruled:

> Given these enactments drawing a clear line between patients on the one hand and former patients on the other, we conclude that the term "patient" in Business and Professions Code section 2960, subdivision (o), referred to a person presently under the care of a psychotherapist and not to a former patient.
>
> We reach the same result with respect to Business and Professions Code section 726.
> (*Id.* at 363.)

The *Poliak* court was silent as to whether, under the circumstances of that case, section 2960, subdivision (j) (gross negligence) would be applicable to the psychologist given that the individual with whom she had sexual relations was deemed a former patient.

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The ruling in *Poliak, supra,* is consistent with the provisions of section 2903 which states:

> No person may engage in the practice of psychology, or represent himself or herself to be a psychologist, without a license granted under this chapter, except as otherwise provided in this chapter. The practice of psychology is defined as rendering or offering to render for a fee to individuals, groups, organizations or the public any psychological service involving the application of psychological principles, methods, and procedures of understanding, predicting, and influencing behavior, such as the principles pertaining to learning, perception, motivation, emotions, and interpersonal relationships; and the methods and procedures of interviewing, counseling, psychotherapy, behavior modification, and hypnosis; and of constructing, administering, and interpreting tests of mental abilities, aptitudes, interests, attitudes, personality characteristics, emotions, and motivations.
>
> The application of these principles and methods includes, but is not restricted to: diagnosis, prevention, treatment, and amelioration of psychological problems and emotional and mental disorders of individuals and groups.
>
> Psychotherapy within the meaning of this chapter means the use of psychological methods in a professional relationship to assist a person or persons to acquire greater human effectiveness or to modify feelings, conditions, attitudes and behavior which are emotionally, intellectually, or socially ineffectual or maladjustive.
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> As used in this chapter, "fee" means any charge, monetary or otherwise, whether paid directly or paid on a prepaid or capitation basis by a third party, or a charge assessed by a facility, for services rendered.

Albeit not directly applicable to the facts of this case, guidance is also found in the definition of "patient" as applied to the psychotherapist-patient privilege. Evidence Code section 1011 states:

> As used in this article, "patient" means a person who consults a psychotherapist or submits to an examination by a psychotherapist for the purpose of securing a diagnosis or preventive, palliative, or curative treatment of his mental or emotional condition or who submits to an examination of his mental or emotional condition for the purpose of scientific research on mental or emotional problems.
> (But see Evidence Code section 900.)

In this case, J.O. believed she was attending therapeutic sessions with Respondent in 1998 when she met Respondent in his office at pre-scheduled times for approximately one hour per session, prior to engaging in sexual contact. Respondent believed the meetings were for the purpose of "chatting" and having extra-marital sex with his friend. Under the circumstances of this case, J.O. did not meet the legal definition of a patient by clear and convincing evidence. Therefore, no discipline shall be imposed against Respondent's license for violations of section 726 or 2960, subdivision (o).

Negligence and Corrupt Acts as to J.O.

A different result is reached with respect to section 2960, subdivisions (j), (n) and (r). Respondent was grossly negligent, not only in connection with J.O., but with all of the family members, individually and collectively. He also engaged in corrupt acts by manipulating J.O.'s attendance at M.O.'s sessions during M.O.'s second course of therapy, and then meeting J.O. in his office at pre-determined times in order to engage in a sexual relationship with her.

Gross negligence has been defined as an extreme departure from the ordinary standard of care or the "want of even scant care." (*Gore v. Board of Medical Quality Assurance* (1970) 110 Cal.App.3d 184, 195-198.)

J.O. terminated her therapy with Respondent in August of 1996. The sexual relationship between Respondent and J.O. commenced in April of 1998. The evidence did not even suggest, much less prove, that the sexual relationship suddenly came into existence immediately after the two-year period following therapy termination lapsed. The "friendship" between Respondent and J.O. began in June or July of 1997 after M.O. returned to therapy, and the nature and intensity of the relationship escalated over the next several months. Then, in April of 1998, it became sexual and remained so through November 20, 1998. The standard of care in 1996 through 1998 required a two-year cooling off period between the termination of therapy and the commencement of an intimate relationship between a psychologist and a former patient. Respondent failed to comport himself within the standard of care in that regard.

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In addition, just as he had an ongoing responsibility not to disclose confidential communications of a patient after the therapeutic relationship ended (see, e.g., Evidence Code sections 1013 and 1015), Respondent had a similar ongoing responsibility to ensure that he do no harm to his former patient. His failure to fulfill that responsibility constituted an extreme departure from the standard of care. Beginning in June or July of 1997, and continuing through November 20, 1998, Respondent isolated J.O., first by offering to be "friends" and by speaking with her in his office after M.O.'s visits and by telephone, and later, by arranging clandestine meetings in his office after hours and on Sundays. Respondent successfully engaged in a course of conduct to seduce J.O. into a sexual relationship with him. He did so despite the fact that he knew that, psychologically, his former patient was an extremely frail individual due to her borderline personality symptoms and her history as a victim of clergy abuse. He had treated her for both problems. Because Respondent had been J.O.'s therapist between 1993 and 1996, Respondent knew how susceptible J.O. was to over-idealization, exploitation and abuse by authority figures, and to the risk of an extra-marital affair. The standard of care prohibited a psychologist from entering into a sexual relationship with such a patient, regardless of the length of time that had lapsed since therapy terminated, because of the high risk of damage to the former patient. Respondent failed to recognize and/or act on the information he had in order to avoid such a damaging relationship with J.O. In so doing, he committed an extreme departure from the standard of care and caused severe damage to his former patient.

Dr. Thomas opined that Respondent's conduct with respect to engaging in a sexual relationship with J.O. constituted an extreme departure from the standard of care. Dr. Berg testified that the sexual relationship constituted a simple departure, and that much of Respondent's conduct leading to and involving the sexual contact was "frowned upon" by the psychological community. Even Respondent himself admitted that, although he did not believe he had deviated from the standard of care, he had deviated from "community standards" in engaging in the sexual relationship with J.O. Respondent did not elaborate on the difference between the standard of care and "community standards." He did testify, however, that by engaging in a sexual relationship with his former patient, he breached his own standards.

Further, by engaging in a sexual relationship with J.O., Respondent so blurred the boundaries between psychologist and patient/former patient that J.O. actually believed she was in therapy with Respondent in 1997 and 1998 while Respondent believed they were meeting solely to engage in an extra-marital affair.

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As stated above, Respondent argued that he believed J.O. was in therapy with another therapist at the time of his sexual relationship with her. However, he offered no evidence to show that he made any attempt to verify such a therapeutic relationship and, if so, whether her relationship with Respondent had been or was being explored. Absent that information, as J.O.'s former psychotherapist, it was incumbent upon Respondent to protect his former patient from psychological harm resulting from a sexual relationship with him.

Dr. Berg opined that, if Respondent had asked M.O. to bring J.O. with her to M.O.'s sessions during M.O.'s second course of therapy, his doing so was appropriate and not below the standard of care. Dr. Berg further opined that J.O.'s subsequent participation in M.O.'s therapy did not make J.O. a patient again. Dr. Berg's testimony in that regard was not credible. Respondent requested J.O.'s presence at the second course of M.O.'s therapy sessions. If J.O. was not there as a patient, then she must have been there as an object of Respondent's sexual desires. That was inappropriate and Respondent's conduct in that regard was below the standard of care since it occurred less than two years after J.O.'s therapy with him terminated, while at least one other family member was still in therapy, without the informed consent of his current patient, and despite the obvious boundary violations extant in that course of conduct. Respondent's conduct was in neither his former patient's nor his current patient's best interests.

Respondent committed extreme departures from the standard of care in numerous ways with respect to J.O. Those departures were described by Dr. Thomas and recorded as factual findings in paragraph 44, above. They need not be reiterated here.

In closing argument, Respondent's attorney argued that a psychologist's former patient is "fair game" for a sexual relationship with the psychologist. That argument is inconsistent with the standard of care. The concept of a former patient being her psychologist's "fair game" is antithetical to the spirit of professional psychotherapy and is expressly rejected.

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Negligence as to the Family

Between 1993 and November 20, 1998, the standard of care required Respondent to avoid blurred boundaries and dual relationships. Respondent failed to comport himself within the standard of care. He combined conjoint and individual therapy with family members in unacceptable and harmful ways, allowing himself to become entangled in family matters disclosed to him by one or more family members about one or more other family members, without disclosure of those matters to him by the other parties. As a result of the Gordian knot presented by the intricacies of four patients' inter-related issues, Respondent was unable to define his role and maintain his objectivity with respect to any one patient, and was unable to properly identify a primary patient. He was unable to keep separate and distinct all of the various consent, boundary, goal and privacy issues raised by the several therapeutic relationships that existed as a result of seeing a family of four in conjoint therapy of various configurations, and each of the four family members in individual therapy as well. This therapeutic entanglement became a therapeutic strangulation for Respondent and for his patients when he entered into a sexual relationship with one of the family members and declined to disclose the relationship's existence to the others.

Respondent missed the point when he explained that he chose to conceal his social relationship with J.O. from M.O. during M.O.'s second course of therapy because he considered J.O. a former patient. The issue was not J.O.'s patient status, but the effect on M.O. of her mother and her psychologist engaging in an extra-marital affair, and the effect on Respondent's ability to serve as an effective therapist. The fact that M.O. saw her mother and Respondent speaking in Respondent's office would not have made disclosure "redundant." Even if M.O. did witness such conversations, the conversations did not reveal the true nature of the relationship and disclosed nothing of the numerous telephone calls between Respondent and J.O.

Much was made during the hearing of Respondent's progress notes indicating that he had discussed consent issues with the various family members. As indicated above, even if such issues were discussed (a matter of some dispute), the complexity of all of the various consent issues was not discussed, and it is unlikely the children understood the ramifications of any consent they may have given. Moreover, none of the family members were informed of Respondent's sexual involvement with their wife/mother. Therefore, they could not have given informed consent to be treated by Respondent while he was so engaged.

As was the case regarding his negligence and corrupt acts with respect to J.O., Respondent committed extreme departures from the standard of care in numerous ways with respect to all four of the family members. Those departures were described by Dr. Thomas and recorded as factual findings in paragraph 44, above. They need not be reiterated here.

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Respondent was grossly negligent and committed repeated acts of negligence in his care and treatment of L.O., J.O., M.O., and E.O. He negligently failed to address their needs as a family; he negligently failed to address their needs as individuals; and by engaging in a sexual relationship with J.O., he negligently betrayed and caused severe damage to her and to the entire family.

The Discipline

Cause for discipline for gross negligence as to all four family members, for repeated acts of negligence as to all four family members, and for corrupt acts as to J.O. having been established, the next issue to be addressed is the nature and extent of the discipline to be imposed on Respondent's license.

Generally, a respondent's acknowledgement of the problems that gave rise to a disciplinary action, and acceptance of responsibility are viewed as positive signs of rehabilitation and may serve as a basis for a finding that a properly conditioned probationary order will adequately protect the public, thus rendering unnecessary an outright license revocation. A respondent's demeanor and credibility factor into such a determination.

As indicated above, Respondent was not entirely credible in his testimony. His answers to numerous questions were evasive and/or non-responsive. In addition, he denied a great many facts established by the clear and convincing testimony of one or more credible witnesses. Some of Respondent's denials are deemed to have been complete fabrications, as exemplified by Respondent's denial of having engaged in sexual intercourse with J.O. even though he admitted to participating in a discussion with her regarding the possibility of his having impregnated her. In addition, it appeared that, rather than accepting responsibility for the damage he inflicted on J.O. and her family, Respondent attempted to distance himself from her by frequently and repeatedly referring to her as "former patient O____."

Further, despite participating in 29 therapy sessions with Dr. McGee, Respondent has not been candid with him, leading Dr. McGee to believe that the affair with J.O., that Respondent initiated and that lasted several months, including multiple instances of nudity, oral copulation and, on one occasion, sexual intercourse, occurred on a single day when J.O. appeared unannounced and seduced Respondent into a single episode of hugging and touching.

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Respondent claims that it was J.O. and her family members, rather than Respondent, who were not credible. (J.O., L.O. and M.O. testified at the hearing. E.O. did not.) That is not the case. L.O. and J.O. settled their lawsuit against Respondent a few years ago, and have repaired their relationship to the extent that, despite their acrimonious divorce triggered by J.O.'s affair with Respondent, they now share a harmonious relationship. Unlike Respondent, L.O., J.O., and M.O. had nothing to gain by testifying dishonestly at the hearing.

Prior to testifying, L.O., J.O., and M.O. each knew that, by testifying as they did, they would be disclosing and exposing each of their family member's intimate and, in some instances, ugly and sordid experiences, conflicts, issues and secrets. J.O., in particular, knew that her testimony would subject her to aggressive and scathing cross-examination specifically designed to discredit her story and attack her credibility. Indeed, the Administrative Law Judge has rarely witnessed a cross-examination more demeaning and humiliating than that to which J.O. was subjected. Yet, J.O., like L.O. and M.O., was forthright and consistent in her testimony. Findings made in this Proposed Decision that are inconsistent with J.O.'s testimony are not intended to infer a lack of credibility, but rather a failure of proof by clear and convincing evidence.

Respondent refuses to accept the full impact of his sexual relationship with J.O. Whether sexual intercourse occurred is not dispositive of the gross negligence issue since other sexual acts were proven and/or admitted by Respondent. However, Respondent's denial of that act, coupled with his numerous other denials, does affect both his rehabilitation and the safety of the public should he be permitted to continue to practice. Respondent's denials of pertinent facts, together with his fabrication of other claims (i.e., his version of the "affair" as he described it to Dr. McGee) evinces a lack of honesty with himself and with the public, an honesty necessary to ensure his rehabilitation. Respondent's lack of rehabilitation means that one cannot conclude he would act differently in the future if faced with circumstances similar to the ones presented in this case. Because the public places perhaps the greatest of all trusts in its psychotherapists to protect it from exploitation and harm at a psychotherapist's own hands, permitting Respondent to continue to practice would present an unacceptable risk to the public health, safety, welfare and interest.

ORDER

WHEREFORE, THE FOLLOWING ORDER is hereby made:

1. Psychologist's License No. PSY 7904, issued to Respondent, Joel L. Siegel, Ph.D., is revoked.

2. Within ninety (90) days of the effective date of this Decision, Respondent shall reimburse the Board the sum of $18,464.68 for its costs of investigation and prosecution.

DATED: November 12, 2004

H. STUART WAXMAN
Administrative Law Judge
Office of Administrative Hearings